EvidenceBriefing

Improving outcomes for residents of care homes

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Key messages

Providers of care in care homes should:

- offer staff training regarding recognition of cognitive states including delirium, supporting meaningful activity, end of life care
- have clear processes in place for access to healthcare
- provide information regarding dementia diagnosis and prognosis
- ensure advance care planning takes place
- offer opportunities to take part in meaningful activity

Commissioners of old peoples' services should:

- support the delivery of Comprehensive Geriatric Assessment (CGA)
- ensure broad involvement of stakeholders including care home providers and patients or representatives to ensure services are tailored
- ensure service specifications include interventions such as cognitive reframing
- ensure services are available and coordinated in relation to end of life care
- ensure stable leadership and clear strategy of overall system
- use of specific models of care can have benefit
- do not neglect long term population strategies to support healthy ageing and prevent increasing disease burden
- support the development of relationships between care homes and service providers, and ensure clear lines of responsibility
- commission targeted training for staff
- ensure evaluation and monitoring is fed back for continuous improvement

Background

Approximately 400,000 people live in care homes in England, a large proportion of whom have restricted mobility, dementia, incontinence and other medical issues[1]. There are three times as many beds in care homes (both residential and nursing homes) as there are in National Health Service (NHS) hospitals.

How care homes work with health and social care services (and vice versa) is an important indicator of system integration. Historically, integration has been poor with marginalisation from NHS services[2,3,4,5], particularly those that offer specialist expertise in dementia,

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rehabilitation and end of life care. The Atlas of Variation reports a 604-fold variation between CCGs in admissions to hospital for care home residents[6]. This issue of Evidence Briefing provides an overview of the evidence around optimising care to care home residents - to improve their health and well-being and to reduce the need for unscheduled care.

Comprehensive Geriatric Assessment

There is robust evidence that Comprehensive Geriatric Assessment (CGA) improves outcomes for vulnerable older people[7]. CGA involves a multidimensional and multidisciplinary approach which generates a problem list designed to tackle the multifactorial, interdependent issues. It establishes goal-orientated management.

Whole system care

Evidence suggests that relationships between care homes and healthcare providers are important in delivering high quality care[2,3]. Continuity of roles and clear lines of responsibility, as well as allocated time for collaboration could help. Specialist input is important such as in undertaking a CGA. Governance and contractual arrangements have been highlighted as being of importance. Clearly defined processes could ensure roles and responsibilities are made explicit leading to improved coordination. Barriers may include high staff turnover, previous experiences and a lack of capacity.

Delivery models

A 'virtual ward' or 'hospital at home' provides an integrated health and social care team a method of delivery for CGA in the community. There is evidence for improved patient satisfaction and reduction in emergency care requests but not for reductions in admissions to hospital overall[8].

Another approach is multi-disciplinary teams (MDTs) with case management. A review reported four stages to this approach: identifying patients, assessing their needs, planning the care they require and responding to rapid changes[9]. Clear protocols are also required to facilitate implementation of care pathways. There is some evidence for improved outcomes for care home residents and reduced hospital admissions but the impact on overall costs is not clear.

Telemedicine involves the use of video technology to facilitate a face to face consultation without the need for patients to travel. There is some evidence to support the use of telemedicine for heart failure and diabetes etc. but no evidence specifically for care home residents[10,11].

Staff education

There is no conclusive research to support a particular nursing model or skill-mix[12]. Poor staff knowledge is associated with increased GP referrals. Three educational priorities that have been identified are: dementia care, personal care and long term conditions[13].

Improving use of medications

The multiple co-morbidities in this patient group result in polypharmacy (>4 drugs) which increases the likelihood of drug interactions and adverse effects. Approximately 7 out of 10 care home residents experience at least one drug error partly due to polypharmacy but also poor documentation[14]. A review of studies involving care home residents found no evidence that medication review, case conferencing, education or technology to support decisions improved mortality, adverse drug events or admission to hospital[15]. NICE guidance on this topic makes recommendations on policies, monitoring of incidents, updating and sharing information, self-administration when possible and staff training[16].

Preventing pressure ulcers

Care home residents are particularly at risk of developing pressure ulcers (high prevalence of cognitive impairment and/or impaired mobility). Moore et al[17] concluded that there was no reliable evidence that using risk assessment tools redusced the risk of the incidence of pressure ulcers. NICE guidance on pressure ulcer prevention and management recommended that multicomponent care plans implemented following a risk assessment are most effective at reducing pressure ulcers[18]. These could include pressure-relieving surfaces, repositioning of patient, skin inspections, continence management and nutrition.

Falls prevention

Falls are common in care home residents. A Cochrane Review on multi-component falls prevention programmes for care home residents suggests a possible reduction in the fall rate[19]. In the care home population vitamin D supplementation is effective in reducing the rate of falls but there is inconsistent evidence regarding exercise programmes. Hip protectors may reduce the risk of hip fractures in older people in residential care with a slight increased risk of pelvic fractures[20]. Acceptability to older people and concordance are barriers to use.

Cognition, mental & physical wellbeing

NICE has published quality standards to improve the mental wellbeing (optimum independence, feeling in control, optimism, having a purpose and sense of belonging) for care home residents[21]. These standards emphasise the need for meaningful activity, the maintenance of personal identity, the recognition of possible mental illness, addressing needs related to sensory impairment, the ongoing monitoring of physical symptoms and access to healthcare. The College of Occupational Therapists has a toolkit to support the implementation of meaningful activity in care homes, including suggestions for activities such as music, movement or group activities[22]. A Cochrane review reported that physical rehabilitation for care home residents may reduce disability with few adverse events, but the effects were small and may not be applicable to all residents[23].

Advance Care Planning

Advance Care Planning (ACP) is of particular relevance in care homes as half of care home residents die within approximately 1.5 years after admission[24]. Advance care planning has been shown to result in a lower likelihood of dying in hospital and improved communication, alongside potential cost savings[25].

Improving care at the end of life

The NICE End of Life Care guideline applies to all care settings[26]. It highlights the need for training in the diagnosis of dying and end of life care, to have a senior clinician responsible for the patient making decisions in conjunction with patients and relatives, to ensure adequate hydration, to distinguish between discussions around Cardiopulmonary Resuscitation and the implementation of end of life pathways, and to ensure equipment and staff are well coordinated, including out of hours.

The Gold Standards Framework is a set of standards designed to ensure high quality end of life care in primary care in use in the UK since 2001[27]. A critical review suggests the framework is effective at improving coordination and communication, and recording patient preference regarding place of death – although evidence was limited, and use of the framework displays significant variation across practices. Ensuring GP engagement, availability, and a champion to drive the implementation of the standards were highlighted as important measures. Qualitative evidence also suggests that community matrons and district nursing

teams can play a vital part in the use of the framework with complementary strengths and expertise though a lack of clarity regarding roles and poor relationships could have a negative impact[28].

Last days of life

The NICE End of Life Care guideline makes specific recommendations on care in the last few days of life. It emphasises the identification of dying, communication, shared decision making, hydration, pharmacological symptom control and anticipatory prescribing[29].

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